STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155019	A. BUILDING	00	COMPLETED 04/18/2012
		155019	B. WING		04/16/2012
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
GARDEN	N VILLA			CURRY PK IINGTON, IN 47403	
(X4) ID		STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
			70000		
		or Recertification and	F0000		
	State licensure s	urvey.			
	Cumulari datar Am	mil 11 12 12 16 17 am d			
	18, 2012	ril 11, 12, 13, 16 17 and			
	16, 2012				
	Facility number-	-00007			
	Provider number				
	AIM number-100275040				
	Survey team:				
	Marla Potts, RN	T, TC			
	Sharon Whitema	an, RN			
	Amy Wininger,	RN (April 16, 17 and 18,			
	2012)				
	Census bed type	X:			
	SNF: 16				
	SNF/NF: 183				
	Total: 199				
	Census payor ty	ne:			
	Medicare: 26	pc.			
	Medicaid: 128				
	Other: 45				
	Total: 199				
	Sample: 30				
	Theses deficience	cies also reflect state			
		accordance with 410 IAC			
	16.2.	accordance with 110 mic			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of correction (X1) provider/supplier/clia (DENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 04/18	LETED	
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	Quality review completed 4/19/12 Cathy Emswiller RN					

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Event ID: 3PON11

Facility ID: 000007

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	IDENTIFICATION NUMBER:					
		A BIIII	BUILDING 00		COMPLETED	
	155019				04/18/	2012
		B. WIIV		ADDRESS CITY STATE ZIP CODE		
PPLIEF	t					
			BLOON			
		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
B)(ii) BY (i) BY (ii) BY (iii)	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons ith each resident's written ation, interview and e facility failed to ensure resafety were uring a shower, by CNA for Resident #130, in was not transferred with uring a shower as lan of care and leg on during the shower, into observed to be aff members, in the as identified on the initial ty, by the Unit Manager to A.M., as cognitively bendant for care. The covided the CNA ing Assistant) assignment me time, dated 4/10/12, skin sleeves when up, eves) to lower legs at all in by using armsdraw sident and sling when	F02		Garden Villa's policy is to have services provided or arranged qualified persons in accordance with each resident's written plat of care. Garden Villa submits the following as evidence of its commitment to compliance with regulatory compliance. I. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. Resident #130 had been identified by nursing assessment as a high risk transfer. The transfer requirement for this resident witten on the certified nursing assignment sheet. The certified nursing assignment sh	by ele in he h or as ed to vas I by f cition ent t now wts	05/07/2012
THE SAME SITE IN THE SAME SAME SAME SAME SAME SAME SAME SAM	MARY S DRY OR 3)(ii) S BY (AN Desprose be prosent be prosent be prosent be prosent be prosent because the prosent by state at 9:3 and dependent by state at	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) 3)(ii) S BY QUALIFIED PERSONS/PER AN DESTROYIGH OF ARTHUR OF THE STATE	AARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) 3)(ii) S BY QUALIFIED PERSONS/PER AN ees provided or arranged by the st be provided by qualified persons nce with each resident's written re. bservation, interview and ew the facility failed to ensure ns for safety were ed during a shower, by CNA A #2, for Resident #130, in ident was not transferred with lift during a shower as the plan of care and leg re not on during the shower, residents observed to be by staff members, in the 30. aclude: 130 was identified on the initial facility, by the Unit Manager at 9:30 A.M., as cognitively and dependant for care. The ger provided the CNA Nursing Assistant) assignment his same time, dated 4/10/12, cated skin sleeves when up, g sleeves) to lower legs at all er turn by using armsdraw een resident and sling when gfull body lift at all times,	AARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) 3)(ii) S BY QUALIFIED PERSONS/PER AN ees provided or arranged by the st be provided by qualified persons noe with each resident's written re. bbservation, interview and ew the facility failed to ensure ns for safety were ed during a shower, by CNA A #2, for Resident #130, in ident was not transferred with lift during a shower as the plan of care and leg re not on during the shower, residents observed to be by staff members, in the 30. Include: 130 was identified on the initial facility, by the Unit Manager at 9:30 A.M., as cognitively and dependant for care. The ger provided the CNA Nursing Assistant) assignment nis same time, dated 4/10/12, cated skin sleeves when up, g sleeves) to lower legs at all er turn by using armsdraw een resident and sling when gfull body lift at all times,	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 ID PREFIX PRY OR LSC IDENTIFYING INFORMATION) 3)(ii) S BY QUALIFIED PERSONS/PER AN es provided or arranged by the st be provided by qualified persons noe with each resident's written e. bservation, interview and ew the facility failed to ensure ns for safety were ed during a shower, by CNA A #2, for Resident #130, in ident was not transferred with lift during a shower as the plan of care and leg re not on during the shower, residents observed to be by staff members, in the 30. Iclude: 130 was identified on the initial facility, by the Unit Manager at 9:30 A.M., as cognitively nd dependant for care. The ger provided the CNA Nursing Assistant) assignment nis same time, dated 4/10/12, cated skin sleeves when up, g sleeves) to lower legs at all er turn by using armsdraw even resident and sling when gfull body lift at all times, ID PREFIX TAG PROUBLES. CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 ID PROUBLES. CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 ID PROUBLES. CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 ID PROUBLES. CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 ID PROUBLES. CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403 BROOMINGTON, IN 47403	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 MARY STATEMENT OF DEFICIENCIES EFFCIENCY MUST BE PERCEDED BY FULL. DRY OR LSC IDENTIFYING INFORMATION) 3(ii) S BY QUALIFIED PERSONS/PER AN es provided or arranged by the sit be provided by qualified persons noe with each resident's written e. bservation, interview and ew the facility failed to ensure ns for safety were ed during a shower, by CNA A #2, for Resident #130, in ident was not transferred with lift during a shower as the plan of care and leg re not on during the shower, residents observed to be by staff members, in the 30. Include: 130 was identified on the initial facility, by the Unit Manager at 9:30 A.M., as cognitively and dependant for care. The ger provided the CNA Nursing Assistant) assignment nis same time, dated 4/10/12, cated skin sleeves when up, g sleeves) to lower legs at all er turn by using armsdraw even resident and sling when g, full body lift at all times, STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403 PREFIX TAG PROFINATE PREFIX TAG PROFINATE PREFIX TAG PREFIX TAG

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Event ID: 3PON11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155019	B. WIN			04/18/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	S.			CURRY PK	
GARDEN	I VILLA				IINGTON, IN 47403	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	During interview A.M., Unit Mana Resident # 130 v getting a shower observed in the s #1 and CNA #2. observed to have wheelchair with body lift pad was resident. CNA # and cut off gauze The resident was tear with steri-straige, and a skin te CNA #1 told CN Resident #130's a proceeded to lift transfer her to that lifted the resident CNA #2's reach, resident with the to bend and her I The CNA's were in her wheelchair resident's back at was observed to right outer breast whimper during told the resident.	ager #3, indicated was in the shower room. Resident #130 was shower room with CNA. The resident was been sitting in the no clothes on. A full sobserved under the took bandage scissors dedressing from both legs. Sobserved to have a skin rips in place to her right ear to her hand. IA #2 to get under the resident up to be shower chair. CNA #1 the and pulled her from they both grabbed for the residents knees observed ower legs touch the floor. The able to place the resident the place on her they are a red place on her they are a red place on her they are a red place on her they are the resident to the transfer. CNA #1			affected. All facility residents in the potential to be affected. In Service training was done with nursing staff regarding followin care plans as directed. Descrit the steps or systemic changes the facility had made or will made to ensure the deficient practice does not recur, including any in-services, but this also shoul include any system changes ymade. Education will be completed with all new staff during orientation and will continue throughout the length their employment regarding following care plans as directe Education has been completed with all nursing staff regarding following care plans as directe Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be completed on 50 residents per week to assure that care plans are being followed as directed nursing administration for at lea 3 month period. Director of Nursing and ADON will ensure that education will be completed with all nursing staff during orientation and then regularly following care plans as	ave all g be ake d ou of d. d d. di be st be by ast
		nold the wheelchair and			directed.Quality Assurance wil	l be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		LDING	00	(X3) DATE COMPL 04/18/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
IAU	he would transfe blanket was place sling which was CNA #1 placed he resident and with resident's arms his shook the resident shower chair most the wheelchair. To her room and dressings could he could be compared to her room and dressings could here indicated the resistant whole have been shower chair most recent minicated the resident #130's or reviewed on 4/15 Diagnoses included: "degenerative most recent minicated the resident was sever impaired and required and requ	r the resident. A bath ed over the full body left in the wheelchair. his arms around the his arms under the fted the resident and hit's bottom to get the oved, then placed her into CNA #2 took the resident alerted the nurse so new be applied to her legs. 1:45 A.M. LPN #1 ident's skin was very hould always be lifted body lift only. 1:45 at 11:00 A.M. led but were not limited to osteoporosis." The mum data set do 3/6/12, indicated the erely cognitively juired extensive of staff members for giene. 1:45 at 11:00 A.M. led but were not limited to osteoporosis. The mum data set do 3/6/12, indicated the erely cognitively juired extensive of staff members for giene.	IAU	given a report monthly regard education. This will be for 3 consecutive months then reviewed for reporting change. Date of completion M 7, 2012		DATE
	u ansiers and acti	ivities of daily living to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		A. BUILDING B. WING	00	COMPLETED 04/18/2012			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	avoid possibility of fractures." Another problem, dated 6/29/11 and updated through 6/12, included "requires full body mechanical lift with 2 assist." Approaches included "transfer to be provided with full body lift and 2 assist." Another problem, dated 3/15/11 for "potential for impaired skin integrity/pressure ulcer related tofragile skin" Approaches included; "leg sleeves on at all times, do not remove for showers until after transferred to shower chair, skin tears on 4/12 and 4/15/12." 3.1-35(g)(2)						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF F	PROVIDER OR SUPPLIER		<u>'</u>	1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN 47403		
(X4) ID PREFIX TAG F0314	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0314 SS=G	PRESSURE SOL Based on the color a resident, the faresident who entressure sores of sores unless the demonstrates that and a resident has receives necessare promote healing, prevent new sore Based on observations are sident who we pressure did not when pressure did not when pressure to the consumer to the consumer to the consumer to a stage IV work Resident #57. Findings include The clinical reconsumer to the consumer to a stage IV work Resident #57. Findings include	mprehensive assessment of icility must ensure that a ers the facility without loes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing. Ation, interview, and the facility failed to ensure as admitted with develop pressure and eveloped the facility he resident was manner that off loaded occyx for 1 of 14 is reviewed for pressure ty sample of 30 in that, admitted with a stage I, I coccyx, which worsened and to the coccyx.	F03	14	Garden Villa's policy is to ensithat a resident who enters the facility without pressure areas does not develop pressure are unless the individual's clinical condition demonstrates that the were unavoidable, and that a resident with pressure area(s) receives the necessary care a treatment to promote healing, prevent infection, and prevent additional pressure areas from developing. Garden Villa submithe following as evidence of its commitment to compliance with regulatory compliance. Descriwhat the facility did to correct deficient practice for each resident cited in the deficiency. Resident #57 was admitted on 3/24/12 with a diagnosis s/p fall with rib fractional RLE tramatic radiculopath realted to fall at home. Reside #57 had a history of previous CVA. Resident #57 had documented low Albumin and Total protein while in the hosp and was being treated for a	eas ney nd nits sth be the	05/07/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155019	B. WIN			04/18/2012
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			CURRY PK	
GARDEN	JVIIIA				IINGTON, IN 47403	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DATE
	indicated, Resident #57 had been				pressure area in addition to his injuries. Upon admission to	5
	admitted on 03/2	24/12.			Garden Villa resident #57 was	
					placed on a pressure reduction	
	During the initia	l tour on 04/11/12 at 9:30			mattress, Xenaderm ordered a	• • • • • • • • • • • • • • • • • • •
	A.M., the Unit N	Manager #2 identified			was assessed to have a dark,	red
		having an unstageable			area on the coccyx. Family	
	wound on the co				reported that no definitive	_
	Would on the to				diagnosis could be made at th hospital to explain why resider	
	Dogidant #57 wa	as observed on 04/16/12 at			had a decline from baseline at	
					home. From admission to this	
	10:50 A.M. lying	_			date resident has remained	
		to the left and his			confused and dependent on s	taff
		ped. The wife and			for most all ADL's even with	
	daughter of Resi	dent #57 were observed			physical and occupational	
	at the bedside at	that time.			therapies involvment. Resider	• • • • • • • • • • • • • • • • • • •
					#57's coccyx was suspected to have deep tissue damage from	
	During an interv	riew with the spouse of			admission so assessments an	
	_	that time, she stated,			interventions were implemente	
	· ·	ays turn him every two			by nursing, dietary and	
		use further indicated she			therapy. To address positionin	g
	_	resident's bedside for			concerns all staff caring for	
					resident #57 were checked off	
	about 20 minutes	S.			proper positioning techniques. Hourly documentation was	
					implemented to verify resident	
		s observed on 04/16/12 at			#57 was repositioned timely.	
	11:50 A.M. lying	•			Describe how the facility revie	wed
	shoulders tilted t	to the left and his			all residents in the facility who	
	buttocks on the b	ped. The wife and			could be affected by the same	• • • • • • • • • • • • • • • • • • •
	daughter of Resi	dent #57 were observed			deficient practice, and state wi	
	at the bedside at that time. During an interview at that time, both indicated his				actions the facility took to corre the deficient practice for any	eci
					resident the facility identified a	s
		been changed since their			being affected. All residents ha	l l
	arrival.	occir changed since then			the potential to be affected by	
	ailivai.				same deficient practice. All	
	D 11 . #55	1 1 044542			nursing staff will be inserviced	
		s observed on 04/16/12 at			proper positioning. Describe the	
	1:45 P.M. lying	in bed with his shoulders			steps or systemic changes the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155019	B. WING		04/18/2012
NAMEOFF	DROLUDED OD GLIDDLIEI		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	K	1100	S CURRY PK	
GARDEN	I VILLA		BLO	OMINGTON, IN 47403	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
	tilted to the righ	t and his buttocks on the		facility had made or will make	
	bed.			ensure the deficient practice of	loes
				not recur, including any in-services, but this also shou	Id
	Resident #57 wa	as observed on 04/16/12 at		include any system changes y	
		in bed with his shoulders		made.All Nursing staff will be	, 54
		t and his buttocks on the		inserviced on proper positioni	ng
	bed.	t and ms battocks on the		techniques. Nursing	
	ocu.			administration will audit 100%	
	D :1	1 1 04/17/10		residents with pressure areas	
		as observed on 04/17/12 at		least three times a day for propositioning techniques and ev	
	9:06 A.M. lying	in bed on his back.		shift by the charge nurse	Ciy
				responsible for that resident's	
	Resident #57 was observed on 04/17/12 at			care. Describe how the correct	
	10:10 A.M. lyin	g in bed on his back.		action(s) will be monitored to	
				ensure the deficient practice v	vill
	During an obser	vation of care on		not recur, ie., what quality	4
	~	0 A.M. CNA #5 and		assurance program will be pu into place. Describe how the	ı
	CNA #6 were o	observed to reposition		corrective action(s) will be	
		his right side. CNA #5		monitored to ensure the defic	ent
		e prop the resident's upper		practice will not recur, ie., who	
		vs, allowing the buttocks		quality assurance program wi	
	1 -	tact with the bed. In an		put into place. Positioning aud will be done for three months	
		CNA #5, at that time, she		reviewed in Quality Assurance	
		ent #57 was to be turned		monthly. After three months the	
				audits will be reviewed for	
	and repositioned	every nour.		a reporting change. Date of	
	D :1 : "57	1 1 04/17/10		completion May 7, 2012	
		as observed on 04/17/12 at			
	12:15 P.M. to be lying in bed with his shoulders tilted to the right and his buttocks on the bed. At that time, the				
	1	ghter were observed to be			
	at the resident's bedside. Both indicated,				
	at that time, the	resident's position had not			
	been changed.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		A. BUILDING B. WING			COMPLETED 04/18/2012		
		100010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 17 107	
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK		
GARDEN	I VILLA				IINGTON, IN 47403		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		s observed on 04/17/12 at		IAG			DATE
		ying in bed with his					
		o the right side and his					
		ed. During an interview,					
		spouse of Resident #57					
		rsician had just left and					
		peen repositioned back to					
		en the physician was					
	finished.	on the physician was					
	misied.						
	During an observ	vation of care on					
	_	A.M. Resident #57 was					
		ring in bed. During an					
	_	time, CNA #3 and CNA					
		were repositioning the					
	_	ft side. CNA #3 then					
		cedure was complete. At					
	_	nt 357 was observed to					
	•	with his shoulders tilted to					
		uttocks on the bed.					
	The second secon						
	In an interview w	vith LPN #2 on 04/17/12					
		identified herself as the					
		leted the admission skin					
	_	indicated she observed					
	the area on the co	occyx upon admission					
		s very dark red, but not					
		er stated, "just looked					
	like a lot of press	-					
	•						
	The Initial Woun	d Visit/Re-evaluation					
	dated 04/10/12 in	ndicated the resident					
	experienced an"	o/a [open area]					
	coccyx/buttocks.	aggravated by					

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		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155019	B. WING		04/18/2012
NAME OF I	DROVIDED OD SUDDIJE	D.	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	N.	1100 S	CURRY PK	
GARDEN	N VILLA		BLOOM	MINGTON, IN 47403	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	pressure"				
	The Wound Pro	gress Note/Reassessment			
	dated 04/17/12 i	ndicated the coccyx			
	wound was a Sta	age IV pressure wound			
	which measured	6.0 X 5.0 X 2.0 with a			
	wound bed of 70	0% fibrin/slough and 30%			
		hat was deteriorating and			
	required debride				
	14	· · · · · ·			
	The Medication	Administration Report			
		ospital] dated 03/22/12 to			
	-	ted the resident was being			
		spital with Xenaderm [a			
		•			
		tectant] for a reddened			
	coccyx.				
	A hospital dogu	ment dated 03/21/12 was			
		Unit Manager, #2 on			
	1 ^	P.M. indicated Resident			
	_	1 area on his coccyx and			
	"area is pink but				
		o be ordered, and PUP			
	Pressure Ulcer	Prevention] plan of care."			
	The Admissis-	Nuraina Aggagamant			
		Nursing Assessment			
	dated 03/24/12 at 12:30 P.M. lacked any documentation of skin condition. The				
assessment included a sketch of a body					
		ten note over the area of			
	the coccyx that i	indicated, "dark red".			
	_	dated 03/24/12 at 12:30			
	P.M. indicated,	"Skin assessment			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18	ETED	
NAME OF P	PROVIDER OR SUPPLIER		<u> </u>	1100 S	DDRESS, CITY, STATE, ZIP CODE CURRY PK INGTON, IN 47403	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR completed [sic]. inner buttocks re			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	A.M. indicated, red area gluteal of purple with 4 sep [four] are clean, with mod [mode [bloody] drainag deep purplestate [and] reposition while in bed" A Wound Report Tissue Damage] related to pressure 0.0 and began or further indicated deteriorated to a measured 6.0 X with 100% black. The Wound Risk 03/25/12 Sectionary documentation history of or currest Stage I-IV pressures assessment indicated high risk for pressure wound Risk Assertations.	Assessment dated in 2 question 10 lacked on the resident had a rent was experiencing a sure wound. The lated the resident was a ssure The most recent lessment dated 04/04/12 ident was a "very high"					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155019		LDING 00		COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The Wound Proto based on Wound 03/31/12 included "turn and repositions hour" A plan of care da "pressure ulcer; but was not limited "T & R [turn and while in bed" The most recent has seen that the seed of circulation (blood of the seed of circulation (circulation (circulation (circulation (circula	Risk Assessment dated d, but was not limited to, ition every 1 [one] ted 03/31/12 for gluteal crease" included, ed to, an intervention of reposition] q 1 hour MDS [Minimum Data dated 03/31/12 indicated as severely cognitively d extensive assist of two sility, had 5 unhealed ble pressure ulcers with ssue injury in evolution sent on admission. Tocedure for Prevention as provided by the HFA Administrator on D A.M. indicated, ation Relative to Pressure ulcers are usually formed remains in thee same attended period of time d pressure or a decrease read of flow) that area,					
	<u>-</u>	ne tissues Pressure nade worse by continual					

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	00	04/18	SURVEY LETED 5/2012	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	3.1-40(a)(1) 3.1-40(a)(2)					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155019	B. WIN			04/18/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1100 S	CURRY PK		
GARDEN VILLA			BLOOMINGTON, IN 47403				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure interventions for safety were implemented during a shower in that Resident #130 was not transferred with a full body lift during a shower as outlined in the plan of care and leg sleeves were not on during the shower, for 1 of 7 residents observed to be transferred by staff members, in the sample of 30. Findings include: Resident #130 was identified on the initial				Garden Villa's policy is that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following as evidence of its commitment to compliance with regulatory compliance. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. All nursing staff that provides care for resident #130 regularly has been checked off on proper technique for transferring resident in/out of shower by nursing		
	on 4/11/12 at 9:3	y, by the Unit Manager 0 A.M., as cognitively			administration. Describe how the facility reviewed all residents in		
		pendant for care. The			the facility who could be affect		
	Unit manager pro				by the same deficient practice, and state what actions the faci		
	(Certified Nursin	ng Assistant) assignment			took to correct the deficient	iity	
		ne time, dated 4/10/12,			practice for any resident the		
	•	skin sleeves when up,			facility identified as being		
		ves) to lower legs at all			affected. All residents have the		
	` •	n by using armsdraw			potential to be affected by this		
		-			practice. Education has been		
	sheet between resident and sling when transferringfull body lift at all times,				completed with all staff regard following care plans as	ing	
	•	body int at an times,			directed.Describe the steps or		
	assist times 2.				systemic changes the facility h made or will make to ensure th	ad	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155019		B. WING			04/18/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1100 S	CURRY PK	
GARDEN VILLA			BLOOMINGTON, IN 47403			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG				TAG	DEFICIENCY)	DATE
	During interview	y, on 4/16/12 at 9:15			deficient practice does not reci	
	A.M. the Unit M	anager indicated			including any in-services, but t	
		as in the shower room		also should include any s		
	getting a shower	Resident #130 was			changes you made. Education be completed with all new staff	
		hower room with CNA			during orientation and will	
		The resident was			continue throughout the length	of
					their employment regarding	
		been sitting in the			following care plans as directe	
		no clothes on. A full			Education was completed with	all
		s observed under the			nursing staff on following care	
	resident. CNA #1 took bandage scissors and cut off gauze dressing from both legs. The resident was observed to have a skin tear with steri-strips in place to her right				plans as directed. Describe ho the corrective action(s) will be	w
					monitored to ensure the deficie	ent
					practice will not recur, ie., what	
					quality assurance program will	
	leg, and a skin te				put into place. Describe how th	ne
	6,				corrective action(s) will be	
	CNA #1 told CN	A #2 to get under			monitored to ensure the deficie	
		arms and the CNA's			practice will not recur, ie., what quality assurance program will	
					put into place. Audits will be	De
	_	the resident up to			completed on 50 residents per	
		e shower chair. CNA #1			week to assure care plans are	
		t and pulled her from			being followed as directed by	
	CNA #2's reach,	they both grabbed for the			nursing administration for at le	ast
	resident with the	residents knees observed			a 3 month period. Two times a	31
	to bend and her l	ower legs touch the floor.			week care for resident #130 windle be observed by nursing	III
	The CNA's were	able to place the resident			administration to assure care p	olan
	in her wheelchair by grabbing at the				is being followed as directed for	
		nd arms. The resident			at least a 3 month period.The	
		have a red place on her			Director of Nursing, or designe	e,
		•			will report monthly to Quality	
	right outer breast and was heard to whimper during the transfer. CNA #1 told the resident "sorry."				Assurance regarding check off	
					for proper transferring technique and following care plans as	1 <u>C</u>
					directed for 3 consecutive mon	iths
	After the shower	was completed, CNA #1			then will review for reporting	
		nold the wheelchair and			change. Date of completion Ma 7, 2012	ly
		r the resident. A bath			1,2012	
	ne would transfe	i die resident. A dath				

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155019		ILDING 00		COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	sling which was in CNA #1 placed in resident and with resident's arms list shook the resident shower chair more the wheelchair. On the wheelchair of the wheelchair of the room and a dressings could be considered the resist fragile and she shousing the whole be considered the resist fragile and she shousing the whole be considered the resist fragile and she shousing the whole be considered the resist fragile and she shousing the whole be considered the resist fragile and she shousing the whole be considered to: "degenerative recent minimum dated 3/6/12, ind severely cognitive required extensive members for train." The care plan incompose of the considered the care plan incompose of the care plan incomposes of the care plan incomposes." A "staff to be extra and activities of the considered the resist for the care plan incomposed the care plan incomposed to th	elinical record was 6/12 at 11:00 A.M. led but were not limited osteoporosis." The most data set assessment, icated the resident was ely impaired and re assistance of two staff isfers and hygiene. eluded a problem, dated led through 6/2012, for etures related to approaches included careful during transfers daily living to avoid					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CON	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
	155019	B. WING		04/18/2012			
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	through 6/12, included "requires full body mechanical lift with 2 assist." Approaches included: "transfer to be provided with full body lift and 2 assist." Another problem, dated 3/15/11 for "potential for impaired skin integrity/pressure ulcer related tofragile skin" Approaches included; "leg sleeves on at all times, do not remove for showers until after transferred to shower chair, skin tears on 4/12 and 4/15/12." 3.1-45(a)(2)						

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